The Vein Center of South Carolina

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone:

Home: _____ Work: _____ Cell: _____

Email: _____

Age: _____ Date of Birth: _____ Marital Status: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Phone:

Home: _____ Work: _____ Cell: _____

Referred By: (check all that apply)

Physician (name) _____ Friend/Patient (name) _____

Newspaper _____ Magazine _____ Web Site _____ Other:_____

Reason for Visit: (check all that apply)

Vein Problems _____ Skin Rejuvenation _____ Laser Hair Removal _____

Botox/Xeomin _____ Dermal Fillers _____ Other _____

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Medical History

Full Name: _____

Date of Birth: _____

Medication(s): *prescription and over the counter medications (vitamins, herbals, etc.)

_____

_____

_____

Allergies: (drugs, topical preparations, latex, tape, etc.)

_____

_____

General Information: (yes/no)

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ If so, how much? _____

Do you exercise? _____ If so, how much? _____

Are you on any type of diet or weight loss plan? _____

Had facial laser resurfacing/deep chemical peeling, last 3 months? _____

Had needle epilation, waxing, or tweezing, last six weeks? _____

Have any tattoos or permanent makeup? _____

Recent sun burn or tan? _____

Female Patients: (yes/no)

Is there **any** chance you could be pregnant? _____ Are you nursing? _____

Do you plan on becoming pregnant in the near future? _____ Using birth control? _____

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Medical History (continued)

Please check all that apply (current or prior)

____ Accutane (last 6 mos)
____ Angina
____ Asthma
____ Auto-Immune Disorders
____ Bleeding Problems
____ Blood Clots
____ Bronchitis
____ Cancer History
____ Cold/Numb Feet
____ Cold Sores/Fever Blisters
____ Current Infection
____Diabetes
____ Headaches/Migraines
____Heart Attack/Problems
____Hepatitis
____ High Blood Pressure
____ HIV/AIDS
____ Joint Pain
____ Keloid Scarring
____ Leg Pain
____ Liver Problems
____ Lupus
____ Mental Disorders
____ Neuro-Muscular Disorders
____ Open Wounds
____ Pacemaker/Defibrillator
____ Phlebitis
____ Photo Sensitivity
____ Rashes
____ Seizures
____ Skin Infection (i.e. psoriasis, eczema)
____ Spider Veins
____ Stroke
____ Sores/Ulcers on Legs
____ Varicose Veins

Surgical History:

_____

_____

_____

Any Additional Problems:

_____

_____

_____

All information provided is true and accurate to the best of my knowledge.

_____ _____

Patient Signature Date